

DOUBLE TROUBLE:
STIGMA AGAINST INDIVIDUALS WHO ARE MENTALLY ILL
AND GAY OR BISEXUAL

A THESIS
SUBMITTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

MASTER OF ART

BY

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ABSTRACT

THESIS: Double Trouble: Stigma Against Individuals Who Are Mentally Ill and Gay or Bisexual

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The following study examined whether people's reactions to an individual differed based on the individual's sexuality and mental illness status. Participants read a vignette about a man who is either heterosexual or non-heterosexual and either does or does not have a mental illness, and completed measures which assessed their level of stigma toward the vignette subject. I hypothesized that there would be an interaction effect between mental illness and sexual orientation on reported stigma. However, the results indicated that the interaction was non-significant. I found that only sexuality had a main effect on warmth and social distance. Given this, there appears to be a discrepancy between the amount of stigma that is reported by those who are sexual minorities and have mental illnesses and how people report feeling about them, potentially indicating that people are only viewing one identity as salient at a time rather than considering both at once.

Keywords: stigma, intersectionality, double stigma, mental illness, sexuality

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Double Trouble: Stigma Against Individuals Who Are Mentally Ill and Gay or Bisexual

Every individual holds a complex array of labels and identities that impact how they view the world, view themselves, and are viewed in the world. These identities and labels interact to form complex individual and collective experiences that can be framed in terms of societal privilege and power, which is known as intersectionality (Parent, DeBlaere, & Moradi, 2013). People with identities that lack societal privilege and power often are stigmatized in society, and those who have two stigmatized labels may experience more prejudice than individuals with only one stigmatized label, which is known as the Double Stigma hypothesis (Gary, 2005). For example, men who are Black-American and are gay or bisexual report experiencing racism and heterosexism (“an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community”; Herek, 1990, p. 316), not only in the broader community, but also experience heterosexism in Black communities, and racism within gay and bisexual communities (Bowleg, 2013).

Further support for the Double Stigma hypothesis can be found in David and Knight’s (2008) study on gay men. David and Knight (2008) recruited 383 gay male participants who varied by age (18 to 34; 35 to 55; and 55 and older) and race (Black-American and White-American). Participants were then asked to self-report how much racism and racial stress they have experienced; how much ageism they have experienced; and their attitudes towards their own sexuality, their attitudes towards gay sexuality in general, and how many people know about their sexuality, which were used to determine levels of homonegativity. David and Knight (2008) found that Black older gay men reported experiencing more ageism than older White men, more

racism than young Black men, and more heterosexism than younger White men, younger Black men, and older White men. These findings demonstrate an interaction effect between multiple marginalized identities and their impact on individual experience.

The concept that having two stigmatized labels can lead to more experienced stigma is also supported by examination of the health impacts of stigma. Studies have shown that those who are discriminated against in society reported experiencing more minority stress, and hence experienced worse mental and physical health outcomes than those with privilege (Frost, Levahot, & Meyer, 2015; Meyer, 1995; Meyer, 2003). Further research has also demonstrated that those with two or more stigmatized identities reported worse physical and mental health than those with only one stigmatized label (Hayes, Chun-Kennedy, Edens, & Locke, 2011), indicating that people who have two or more stigmatized identities may experience more frequent or more severe instances of prejudice.

However, although there is some research examining how people with two or more stigmatized identities self-report more experiences with stigma than those with one, and suffer more health consequences as a result, little research has examined whether individuals with two or more stigmatized identities are indeed perceived more negatively by others. It is important to evaluate how individuals with two stigmatized identities are perceived to confirm the concept of double stigmatization, as it would demonstrate that the lived experiences of those with two or more stigmatized identities are grounded in the reality of how they are viewed by others.

Theoretically, those who both have a mental illness and identify as sexual minorities are doubly marginalized as members of two different denigrated groups, and there has long been an inextricable link between stigma of non-straight individuals and stigma of mentally ill

individuals. Historically, non-straight attractions have been categorized as a mental illness (Harris & Licata, 2000) and even in more modern times, pathologizing beliefs about non-straight individuals are still endorsed by some (Dyar, Lytle, London, & Levy, 2017; Eliason, Donelan, & Randall, 1992; LaMar & Kite, 1998). It should therefore be reasonable to conclude that those who both identify as non-straight and are diagnosed with a mental illness may experience an interaction of these identities on the levels of stigma they endure. This is somewhat demonstrated in Kidd, Veltman, Gately, Chan, & Cohen's (2011) qualitative findings that those who were both mentally ill and sexual minorities reported experiencing more discrimination and exclusion due to both their mental health status and their sexual identity. Yet, the scope of Kidd and colleagues' (2011) study is limited, and more research is needed to examine the breadth of the issue. For example, Kidd and colleagues' (2011) study did not examine whether people perceived those who have a mental illness and are sexual minorities in a negative way. Moreover, the stereotypes that are placed upon those who have a mental illness and are sexual minorities were not examined in Kidd and colleagues' (2011) study. Thus, further research examining how other people view those who have a mental illness and are a sexual minority is needed to confirm and expand upon the findings of Kidd and colleagues' (2011) study.

For the purposes of this study, both mental illness and sexual minority identity were studied in conjunction with each other. Although there is much research on the stigma endured by those who were diagnosed with a mental illness (Corrigan et al., 1999), there is little research looking at how the addition of other stigmatized labels impacts how those with mental illnesses are perceived. Moreover, although those who are both sexual minorities and mentally ill report experiencing stigma in the gay community, in mental health communities, and in broader society

(Kidd et al., 2011), there are no studies examining how people actually view individuals who both identify as a sexual minority and have a mental illness. This paper thus sought to examine how an individual who is both a sexual minority and is diagnosed with a mental illness may be perceived by others.

A better understanding of whether people who are both sexual minorities and have a mental illness endure more severe stigma than those with only one minority status is important and useful to understand from both a social justice perspective and from a clinical perspective. From a social justice perspective, activists in both the mental health communities and sexual minority communities may overlook those who are both mentally ill and sexual minorities. Research on how those who are both mentally ill and sexual minorities are perceived may highlight the need for activism for this subgroup, and perhaps encourage collaboration amongst these activist groups. Additionally, this is practical knowledge for clinicians who wish to understand the experiences of their clients, and how other people may perceive their clients. This is especially important given that double minority status can lead to worse mental and physical outcomes (Hayes et al., 2011), and thus clients who are both sexual minorities and have mental illnesses might need special consideration.

Conceptualizing Stigma

Multiple definitions of stigma have been utilized in past research, making the definition of stigma into a rather nebulous concept (Link & Phelan, 2001). For example, stigma has previously been defined as “an attribute that is deeply discrediting” (Goffman, 1963, p. 3); a deviation from a social norm (Stafford & Scott, 1986); or as having a characteristic that indicates a social identity that is devalued in a particular social context (Crocker, Major, & Steele, 1998).

However, these definitions seem to only grasp at part of the concept. Thus, for the purposes of this study, stigma is defined as use of stereotypes and “execution of disapproval, rejection, exclusion, and discrimination” (Link & Phelan, 2001). This definition was given preference as it captures the multiple ways in which stigma can manifest: Cognitively, affectively, and behaviorally.

Cognitive Component of Stigma

Stereotype content model. Stereotypes are a cognitive form of stigma as they link groups to negative attributes based on a label (Link & Phelan, 2001). The Stereotype Content Model (Fiske, Cuddy, Glick, & Xu, 2002) is commonly used to assess people’s beliefs of ingroup and outgroup members. The model proposed that stereotypes of both ingroup and outgroup members tend to cluster around two dimensions: warmth and competence.

Furthermore, typically, people associate both higher warmth and higher competence with their ingroup. However, people usually perceive outgroup members as being lower on warmth, competence, or both.

There are five sub-categories under which stereotypes of a group can fall: high warmth-high competence, low warmth-high competence, high warmth-low competence, low warmth-low competence, and groups in the middle (neither high nor low on both competence and warmth). Groups that are typically privileged in society, such as people who are Christians and people who are White, are often rated high on both warmth and competence (Fiske et al., 2002). According to Fiske et al. (2002), groups that are considered low warmth and high competence are often envied and admired, such as professionals and people who are Asian, whereas groups that are believed to be high in warmth and low in competence, such as people who are elderly and people

who are disabled, are most often pitied. Groups that are both perceived as low in competence and warmth, such as people who are poor or on welfare, are given contempt. Finally, groups that are neither high nor low on both warmth and competence, such as those who are blue-collar workers and people who are Muslim, are neither envied, admired, pitied, or given contempt.

People with mental illness as a broader group are considered to be low in both competence and warmth (Sadler, Meagor, & Kaye, 2012), but when examining their subtype, or diagnosis, these stereotypes shift. Sadler and colleagues (2012) asked 74 participants to consider 13 groups: people with addictions, people who are homeless, people with multiple personality disorder, people with schizophrenia, people with anxiety/phobia, people with bipolar disorder, people with depression, people with eating disorders, people with obsessive compulsive disorder, people with Alzheimer's, people with intellectual disabilities ("mental retardation"), people with sociopathy, and violent criminals. Participants were asked to use four different warmth traits and four different competence traits to assess how warm or competent they believed "Americans in general" thought each group to be (e.g. "In general, how much do Americans believe that people with schizophrenia are friendly?"). Sadler and colleagues (2012) found that the groups rated fell into four different clusters. Participants rated people with addictions, schizophrenia, multiple personality disorder, and those who are homeless as low in both warmth and competence; rated those with anxiety/phobia, bipolar disorder, depression, eating disorders, and obsessive compulsive disorder as neither high nor low in both competence and warmth; rated people with Alzheimer's and intellectual disabilities ("mental retardation") as high in warmth but low in competence; and rated those with sociopathy and violent criminals as low in warmth and neither high nor low in competence. This study demonstrates how, depending on diagnosis, people with

a mental illness can be viewed quite differently. Notably, no diagnostic group was rated highly in both warmth and competence, indicating that no diagnosis is viewed in a highly positive way.

Previous research has examined where sexual minorities fall in the stereotype content model. People tend to perceive lesbian women as high in competence, but low in warmth, indicating that they are respected but not liked (Fiske, 2012; Mize & Manago, 2018). People often perceive gay men as being low in competence and high in warmth, indicating that they are liked but not respected (Mize & Manago, 2018), though an earlier study found that gay men were rated as neither low nor high in either warmth or competence (Fiske et al., 2002). Additionally, people tend to perceive bisexual men and women as low in both warmth and competence, indicating they are neither liked nor respected (Mize & Manago, 2018). It is notable that bisexual men and gay men are rated differently on traits of warmth and competence. This demonstrates how bisexual men and gay men are being perceived in a different way, and thus highlights the importance of studying gay men and bisexual men as two unique groups. Moreover, it is important to acknowledge that gender impacts perceptions of sexual minorities. People often perceive lesbian women and gay men in highly distinct ways (Fiske et al., 2002), and view bisexual men more negatively than bisexual women (Herek, 2013). However, although gender is a critical factor, this is beyond the scope of the current study, which is focused on sexual orientation without examining the effects of gender.

Interestingly, there is limited research examining how intersectionality impacts warmth and competence. It may be that having two marginalized identities would cause them to be perceived as less warm and less competent than either marginalized identity alone. Given how people often view those who are sexual minorities as outgroups (not high in both competence

and warmth), and those with mental illnesses as low in both warmth and competence, depending on the disorder, it would stand to reason that there may be additive effects of stigma—that is, a person who is a sexual minority and has a mental illness may then be viewed as less competent and less warm than a sexual minority who is not mentally ill, or a person who is straight but has a mental illness, due to the marginalization of both identities.

Other stereotypes of those with mental illness. Although warmth and competence are valuable components of stereotypes, further discussion of additional stereotypes held toward those with mental illnesses is necessary to have a more complete understanding of societal perceptions and the nuances behind them. A literature review conducted by Parcesepe and Cabassa (2013) sought to examine public stigma that individuals with mental illness endure. They analyzed 36 publications regarding members of the public’s opinion of people with mental illness. They found that people frequently believed those who have mental illnesses are a danger to themselves and others, viewed them as lazy or incompetent, viewed them as criminal, and perceived their mental illnesses to be shameful (Parcesepe & Cabassa, 2013). Further research has demonstrated that these stereotypes also contribute to the beliefs that those with mental illnesses should be feared and isolated, are irresponsible and incapable of making the “right” decision for themselves, or are child-like and are in need of constant and patronizing care (Corrigan, 2000; Taylor & Dear, 1981). These beliefs appear consistent with findings that people view those with mental illness as neither warm (as they are viewed as dangerous and criminal; Parcesepe & Cabassa, 2013) or competent (as they are viewed as irresponsible and incapable of agency; Corrigan, 2000; Taylor & Dear, 1981). Moreover, these beliefs indicate that respondents desire social distance from people with mental illness. For example, participants reported that

they deemed it more appropriate for a person with a mental illness to be isolated and constantly taken care of (e.g. in a psychiatric hospital) than out in public (Taylor & Dear, 1981).

Stereotypes of gay and lesbian people. People who are gay or lesbian endure stereotypes that are rooted in the perception that they violate gender norms, which may help explain how they are rated on warmth and competence. Kite and Deaux (1987) sought to examine the perceptions that people have of gay men and lesbian women. Undergraduate participants were randomly assigned to list the characteristics that they associated with one of four groups (straight men, straight women, gay men, and lesbian women). Participants rated gay men as more feminine and less masculine than they did straight men, and perceived gay men to be similar to straight women. They also rated lesbian women as less feminine and more masculine than they did straight women, and perceived lesbian women to be similar to straight men. Blashill and Powlishta (2009) replicated Kite and Deaux's (1987) study, conceptually and methodologically. Consistent with previous research (Kite & Deaux, 1987), participants still rated gay men as more feminine and less masculine than straight men. They also still rated lesbian women as more masculine and less feminine than straight women. This replication indicates that these stereotypes have remained stable in the last 30 years.

Other researchers reported that people stereotyped lesbian women as people who want to seduce straight women, want to be men, are too aggressive and overt with their sexuality, should not be near children, and spread sexually transmitted diseases (STDs; Eliason, Donelan, & Randall, 1992). People stereotyped gay men as people who have overbearing mothers, are weak, and are sexually perverse (LaMar & Kite, 1998). These stereotypes suggest that people hold negative stereotypes toward gay men and lesbian women for violating gender roles.

Since research found that people rate lesbian women as being similar to straight men, and rate gay men as being similar to straight women (Kite & Deaux, 1987), this helps potentially explain why lesbians are rated as high in competence, but low in warmth, which is close to how straight men are perceived. In addition, people rate gay men as high in warmth but low in competence, which is similar to perceptions of straight women (Mize & Manago, 2018). Given that people view both lesbian women and gay men as more similar to their opposite gender, gay men and lesbian women may be viewed more negatively for violating gender norms. In an experiment by Cohen, Hall, and Tuttle (2009), participants read two vignettes about two fictitious students. Participants were either randomly assigned to read about two gay men (one masculine, one feminine) or two lesbian women (one masculine, one feminine). Participants then rated how much they liked each vignette target on a 1 (*Not at all*) to 7 (*Extremely*) scale. They found that lesbian women who are considered masculine and gay men who are considered feminine were liked less than lesbian women who are considered feminine and gay men who are considered masculine, supporting the notion that sexual minorities are more disliked when they do not conform to societal expectations about gender, in which men must be masculine and women must be feminine.

Stereotypes of bisexual people. Research to this point has primarily focused on lesbian and gay stigma, whereas research on stigma towards bisexuality has not been explored as thoroughly (Worthen, 2013). Although there is overlap between how people perceive lesbian women, gay men, and bisexual people, such as the belief that all three groups are likely to pass STDs to their partners (Eliason et al., 1992; Spalding & Peplau, 1997), there are also unique differences among the groups. For instance, although all three groups experience heterosexism,

monosexism is experienced by bisexual people, but not by gay men and lesbian women (Dolan, 2013). Monosexism is the belief that a person can or should only be attracted to one gender, which dismisses bisexuality by its very nature (Dolan, 2013). Thus, since lesbian women and gay men experience attraction only to their same gender, monosexism as a concept does not impact how they are perceived.

The monosexism experienced by those who are bisexual may explain why the stereotypes placed on bisexual people differ from those placed on lesbian women and gay men. Although studies have found that gay men, lesbian women, and bisexual people are all viewed as sexually deviant (Eliason et al., 1992; Spalding & Peplau, 1997), bisexual people are especially viewed as aberrant due to assumptions about what being attracted to more than one gender means. These assumptions are well-illustrated in Dyar et al.'s (2017) study. Dyar and colleagues had a heterosexual undergraduate sample, a lesbian and gay community sample, and a heterosexual community sample read one of eight randomly assigned vignettes about a person. The vignettes were nearly identical, though they differed in the gender of the person (male or female), the sexuality of the person (straight, gay, lesbian, or bisexual), and the genders of the person's current and previous relationship partners (all men, all women, or a mix of both). Participants then answered questions assessing how non-monogamous they thought the person in the vignette was, how likely it would be for the vignette person's sexuality to change, and how stable the participants perceived bisexuality to be. Dyar and colleagues (2017) found that in the heterosexual community sample, participants rated bisexual targets as more likely to change their sexual orientation label and as more sexually irresponsible than lesbian, gay, or straight targets. In all samples, participants viewed bisexual targets as more likely to change their sexual identity

label. In the heterosexual community sample, participants rated bisexual targets as more sexually irresponsible than heterosexual targets, but there was not a significant difference between bisexual targets and lesbian/gay targets. Participants also believed bisexual targets to be more likely to want a non-monogamous relationship in the future, indicating that people perceived bisexual people as being less willing or able to maintain long-term monogamous relationships.

Dyar and colleagues' (2017) findings have also been consistent with previous research. For instance, their findings on the sexual stereotypes of bisexual people were consistent with those reported by Spalding and Peplau (1997). Spalding and Peplau (1997) used an experimental design in which heterosexual college students were presented with a vignette in which the gender of the vignette target varied (man or woman), the gender of their partner varied (same- or other-gender), and the sexual orientation of the target varied (heterosexual, homosexual, or bisexual). Participants then rated the targets and the relationship on sexual monogamy, sexual riskiness, trust, sexual talent, and relationship quality. They found that compared to heterosexual targets, participants rated bisexual targets as less monogamous, more likely to pass a sexually transmitted disease onto their partners, and more sexually skilled, whereas compared to gay and lesbian targets, participants rated bisexual targets as more likely to give their partner a sexually transmitted disease and less sexually skilled. Moreover, the gender of the bisexual target's partner was irrelevant in how they were perceived, and the targets in other-gender relationships were not rated more positively than those in same-gender relationships.

Additionally, Dyar and colleagues' (2017) findings on the perceived instability of bisexual people's sexual identity were consistent with those reported by Yost and Thomas (2012). Yost and Thomas (2012) had heterosexual college students answer two open-ended items

about their perceptions of bisexual men and women (e.g. “When you think of a bisexual (woman/man), what comes to mind?”). The open-ended items were coded according to themes based on stereotypes of bisexual individuals (defining bisexuality, really homosexual, really heterosexual, masculine, feminine, liberal, sexy, negative). They found that the sexual identity of people who are bisexual was often in doubt, so that participants viewed bisexual men as actually gay, and viewed bisexual women as actually straight. Yost and Thomas’ findings, along with the finding from Dyar and colleagues’ study that bisexual identity is seen as prone to change, illustrate that bisexuality is not being taken seriously as a valid sexuality. Instead, bisexuality is often ignored, assumed to be temporary, and devalued (Alarie & Gaudet, 2013). These factors may discourage people who are bisexual from divulging their sexuality to others, as they may not only encounter the stigma of being a sexual minority, but may additionally need to convince people of the existence and validity of their sexual orientation (Rust, 2000).

Notably, there have not been any studies examining which stereotypes may be activated for those who are both sexual minorities and have a mental illness. For example, there is a lack of studies examining intersectionality using the stereotype content model. Given how people often view gay men as low in competence (Mize & Manago, 2018), and view those who have mental illnesses as low in competence and warmth (Sadler et al., 2012), people may perceive a gay man who has a mental illness as less competent and less warm than either a gay man without a mental illness, or a straight man with a mental illness. Moreover, based on the preconception that bisexual people are likely to change their sexuality (Dyar et al., 2017) and that those with mental illnesses are incapable of agency (Taylor & Dear, 1981), people may be more likely to view those who are both bisexual and have a mental illness as confused (and thus, less

competent) compared to a straight person with a mental illness or a bisexual person without a mental illness. These questions have as of yet been unexplored empirically. This study sought to make clear which stereotypes are being activated for those with both marginalized identities through analyzing ratings of warmth and competence.

Affective Component of Stigma

How people tend to feel towards a group is an important aspect of stigma, as can be seen by the inclusion of “disapproval” in the definition provided by Link and Phelan (2001). This study utilized the concept of social stigma in order to examine disapproval and prejudice. Although social distance is considered a behavioral proxy (Lauber, Nordt, Falcato, & Rossler, 2004), social distance is frequently conceptualized as an affective measure (Karakayali, 2009). For example, the creator of the Bogardus Social Distance scale asserts that, “in social distance studies the center of attention is on the feeling reactions of persons toward other persons and toward groups of people,” (Bogardus, 1947, p. 306).

Feelings towards the mentally ill. People tend to have negative feelings towards those who have mental illnesses (Parcesepe & Cabassa, 2013). Moreover, these negative attitudes become prevalent at the mere label of a mental illness. In a mail survey study by Socall and Holtgraves (1992), participants were randomly assigned a vignette of an individual, who differed on psychiatric symptomology (i.e. they showed symptoms of Generalized Anxiety Disorder, Major Depressive Disorder, or Chronic Schizophrenia), and the label for their symptomology (i.e. their symptoms were attributed to a physical condition, or a mental condition). For example, one target was described as experiencing heart palpitations, nausea, and dizziness at a restaurant, was taken to the hospital, and was then either diagnosed with Generalized Anxiety Disorder (a

mental illness) or a food allergy (a physical condition). Participants then rated how willing they would be to interact with the target, completed a social distance measure, and stated what their beliefs were about the target. The researchers found that participants were less willing to interact with the mentally ill target than with the physically ill target, even though the symptomology was the same, suggesting that the mere label of mental illness is enough to create stigma. There was also an effect seen for level of severity in symptoms; greater severity of symptoms was linked to more avoidance, regardless of the cause, indicating that those who act mentally ill will be more likely to be rejected. This study demonstrates that both the label of mental illness and symptomology can independently bring about disapproval and rejection. One could then infer that when both symptoms and a label of mental illness are present, an individual will be even more likely to endure disapproval and be rejected. Notably, in the Socall and Holtgraves (1992) study, those who stereotyped the mentally ill target as being more unpredictable and less likely to recover were more likely to avoid the target, which further demonstrates a link between negative stereotypes and a preference for social distance.

Feelings towards gay and lesbian people. In conjunction with experiencing stereotypes, gay men and lesbians also endure prejudice and disdain due to the pervasiveness of modern homonegativity. Modern homonegativity is defined as negative attitudes towards gay men and lesbian women based on the beliefs that discrimination against same-sex attracted people is no longer relevant and important, that gay men and lesbian women should not be trying to change the status quo, and that gay men and lesbian are too overt about their sexualities (Morrison & Morrison, 2011). A study examining the attitudes of college and university students found that 60% of American male students sampled agreed that “Gay men should stop complaining about

the way they are treated in society and simply get on with their lives,” and 47% of American female students sampled agreed that, “Lesbian women have become far too confrontational in their demand for equal rights” (Morrison, Morrison, & Franklin, 2009). Another study by Morrison and Morrison (2011) that looked at a sample of 1,161 university employees found that 32% to 35% of respondents thought that gay men and lesbians “should stop making a fuss about their sexuality/culture”; 33% thought that gay pride celebrations are “ridiculous”; 38% to 40% disagreed with use of tax dollars to support gay men’s organizations and lesbian women’s organizations; and 23% to 32% agreed that gay men and lesbians should “stop shoving their lifestyle down other people’s throats.” A further study by Morrison and Morrison (2011) examined the attitudes of 196 community members. They found that 62% of their sample agreed that gay men should stop “making a fuss of their sexuality/culture” if they wanted to be treated like everybody else; 58% agreed that “gay men should stop shoving their lifestyle down other people’s throats”; and 71% disagreed that “Gay men who are out of the closet should be admired for their courage.”

Additionally, a recent study examined how those in a community sample feel about sexual and gender minorities using a feelings thermometer, with 100 indicating complete warmth towards a group, and 0 indicating complete coldness towards a group (Norton & Herek, 2013). Norton and Herek found that people felt colder towards lesbian women (42.10) and gay men (38.89) than they did towards women in general (67.56) or men in general (62.44). Moreover, in a national survey, 39% of the US public reported they would be upset if their child came out as gay or lesbian (Pew Research Center, 2015), indicating a desire for social distance. The findings of these studies indicate that heterosexuals still harbor negative attitudes and feelings towards

gay men and lesbian women, both in community samples and in more liberal populations.

Feelings towards bisexual people. The stereotypes about bisexuality may explain why bisexual individuals, especially bisexual men, are less accepted than lesbian and gay individuals (Eliason, 1997, 2001; Herek, 2002). While measuring acceptance using a feelings thermometer, Herek (2002) found that when participants rated multiple groups (such as religious groups, gay and lesbian people, people who inject illegal drugs, ethnic and racial groups, bisexual people, people who have AIDS, and people who are for or against abortion), bisexual people were rated second to last in warmth, second only to injecting drug users. Moreover, 11% of participants gave bisexual men a rating of 0, and 9% of participants gave bisexual women a rating of 0, the lowest possible thermometer score. Additionally, these findings were replicated by Norton and Herek (2013), as people rated bisexual men (34.93) lower in warmth on a feelings thermometer than gay men (38.89), and rated bisexual women (40.49) lower in warmth than lesbian women (42.10). Meanwhile, Eliason (1997, 2001) found that heterosexual undergraduate participants were more disapproving and disgusted by bisexual men, in comparison to lesbian women, gay men, and bisexual women. Heterosexual participants were also more disapproving of both bisexual men and women than they were of gay men and lesbians, and three-quarters of these participants felt they were “very” or “somewhat” unlikely to have a sexual relationship with a bisexual partner, which indicates endorsement of social distance. Notably, there have been few studies which examine social distance towards sexual minorities, though there is evidence that those who disapprove more of same-sex attraction may desire more social distance from lesbian women, gay men, and bisexual people than those who approve of same-sex attraction (Hinrichs & Rosenberg, 2002).

Importantly, there has not yet been a study examining how people feel towards those who are both a sexual minority and have a mental illness. As people often feel negatively towards those who are sexual minorities or have a mental illness, it is likely that people who are both will endure even more affective stigma than those who are only a sexual minority or have a mental illness. This study explored the extent to which people have negative feelings towards those who are both a sexual minority and have a mental illness by examining feelings towards the vignette target and how much social distance participants desire from the vignette target. The findings might also contribute to the literature on social distance, as there is a dearth of studies that examine how intersectionality impacts social distance.

Behavioral Component of Stigma

Behavioral components of stigma include rejection and exclusion (Link & Phelan, 2001). These can occur both on an interpersonal level, with a marginalized individual being rejected by those they know and excluded as a result, and on an institutional and systematic level, such as through policies and laws that lead to rejection of marginalized individuals and exclude them from the access of civil rights and power (Link & Phelan, 2001). These broadly can be referred to as discrimination. Discrimination will not be measured in this study. However, behavioral components of stigma can often be considered the implications of cognitive and affective stigma (Link & Phelan, 2001), and thus are worth discussing here to highlight the importance of broadening our understanding of stigma, which will hopefully lead to interventions in the future.

Rejection and exclusion of people with mental illness. People who have mental illnesses are discriminated against in a variety of ways. In terms of institutional and systematic discrimination, Corrigan, Thompson, Lambert, Sangster, Noel, and Campbell (2003) found that

participants with mental illnesses reported high rates of discrimination due to psychiatric disability; 51.7% reported employment discrimination, 23.7% reported educational discrimination, 32.2% reported housing discrimination, and 26.9% reported discrimination from law enforcement. Other studies have found that one in three people with mental illnesses have reported being turned down a job or having a job offer rescinded once their mental health status became known (Stuart, 2006). They are often in lower paying jobs and have limited career advancement opportunities, and this discrimination is often due to prejudice from their employers and coworkers, historical disadvantage, structural disincentives, and policy neglect (Stuart, 2006). Moreover, many states have policies that restrict the rights of people with mental illnesses (Corrigan, Markowitz, & Watson, 2004). Approximately one third of the 50 U.S. states limit the rights of people with mental illness to vote, participate in juries, and hold an elective office, which also denies them institutional power (Corrigan et al., 2004). Furthermore, their rights are also limited in the family domain, such that between 42% and 52% of states limit the legal rights of people with mental illness to remain married, and over 40% limit the child custody rights of parents with mental illness (Corrigan et al., 2004).

Another form of systematic discrimination that people with mental illness endure is how they are portrayed to the general public through the use of media (Corrigan et al., 2004). People with mental illness are frequently portrayed as unusual, different, and dangerous in mass media (Klin & Lemish, 2008). A study that analyzed the portrayal of people with schizophrenia in cinema found that in the movies they examined, the majority of schizophrenic characters acted violently towards themselves or others, with one third of those characters engaging in homicidal behaviors and a quarter committing suicide (Owen, 2012). Moreover, those with mental illness

are portrayed as violent in the news (Whitley & Berry, 2013). A study that analyzed Canadian newspapers from 2005 to 2010 found that 40% of newspaper articles about people with mental illness focused on danger, violence, and criminality (Whitley & Berry, 2013). Although the portrayal of people with mental illnesses in mass media may not intuitively appear to be a form of institutional discrimination, it is important to note that how groups are represented demonstrate the norms of industry and society, with reporters and entertainers often choosing to sensationalize mental illness and violence (Corrigan et al., 2004). Furthermore, the depiction of people with mental illness as violent increases the negative perceptions the public holds of those with mental illness (Corrigan, Powell, & Michaels, 2013), thus contributing further to cognitive and affective stigma.

In terms of interpersonal stigma, research repeatedly shows that people who have mental illnesses experience disproportionately high levels of violence (Goodman et al., 2001). People with mental illness suffer a high prevalence of victimization in physical and sexual assault, with women experiencing sexual assault more often than men, and men experiencing physical assault more often than women (Goodman et al., 2001). A study by Coker and colleagues (2002) found that 28.9% of women and 22.9% of men with serious mental illnesses had experienced physical, sexual, or psychological interpersonal violence during their lifetime. Additionally, people with mental illness are also over twice as likely to be victims of verbal abuse and harassment (41%) compared to people in the general population (15%), and this harassment often was in reference to their mental health problems (Berzins, Petch, & Atkinson, 2003). Thus, there is sufficient evidence to show that people with mental illness are discriminated both on an interpersonal level and on an institutional and systematic level.

Rejection and exclusion of sexual minorities. Gay men and lesbian women still are discriminated against in society, which can partially be seen in which rights people believe they should have. According to a 2017 Pew Research survey, although approval ratings for same-gender marriage has grown to 62%, a third of the United States public still opposes same-gender marriage (32%). Approximately a third (35%) of the United States public was found to view same-gender couples adopting children as negative (Pew Research Center, 2013). Additionally, half of United States citizens (48%) believe that wedding business owners should have the right to refuse service to same-gender couples based on their religious beliefs (Pew Research Center, 2016b), and a quarter (26%) report being less likely to support a gay or lesbian presidential candidate (Pew Research Center, 2016a). These reports are troubling, as they show that discriminatory attitudes, such as not wanting gay men or lesbian women to be in positions of power or to receive goods and services, are still fairly prevalent in the United States, despite the overall increase in acceptance towards sexual minorities in the last two decades (Pew Research Center, 2017).

These attitudes are also reflective of the real-world experiences of many sexual minorities. Studies have shown that sexual minorities often experience institutional and systematic discrimination, such as with discrimination in housing, employment, and medical care (Kreiger & Sidney, 1997). Herek (2009) found that in a sample of 662, one in ten sexual minority individuals reported experiencing housing or employment discrimination. Moreover, on an interpersonal level, approximately 20% of the sexual minority individuals in Herek's (2009) study were victims of a person or property crime based on their sexual identity, and half reported experiencing verbal harassment. Youth that are sexual minorities are overrepresented in

homeless youth housing facilities, and more likely than straight homeless youth to experience violence in these facilities (Hunter, 2008). Given the experiences of sexual minority individuals and the discriminatory attitudes of community populations, it is evident that behavioral stigma is present and causing real world problems (such as lack of housing and physical harm) for sexual minority individuals.

Bisexual stigma in the lesbian and gay community. It is important to note that bisexual individuals experience rejection and exclusion, not only from straight people, but also from gay and lesbian people (Dyar et al., 2017). For example, gay men and lesbian women may endorse stereotypes about bisexual individuals; Dyar and colleagues' study found that those in the lesbian and gay community sample in the bisexual conditions rated the vignette person as more likely to change their sexuality and prefer a non-monogamous relationship than those in the other conditions. These stereotypes appear to have negative impact on the way lesbian and gay individuals perceive bisexual individuals; although one might expect the gay and lesbian community to be a place of support and affirmation for bisexual individuals, bisexual individuals often struggle to fit in to gay and lesbian spaces (Borver, Gurevich, & Mathieson, 2001), report being ostracized within the gay community (LeBeau & Jellison, 2009), and suffer stigma and community rejection from the lesbian and gay community (McLean, 2008; Weiss, 2003). They struggle to convey their sexuality as credible to both those in the straight community and those in the lesbian and gay community (Borver et al., 2001; Roberts, Horne, & Hoyt, 2015), which may potentially be the result of societal monosexism. Monosexism and devaluing of bisexuality may explain why bisexual people often report less connection to sexual minority communities (Balsam & Mohr, 2007); studies have shown that bisexual women tend to participate less in

sexual minority communities than lesbian women (Morris & Rothblum, 1999), and bisexual men report low levels of contact with the gay community (McKirnan, Stokes, Doll, & Burzette, 1995). From this, one may be able to infer that bisexual individuals may generally be more stigmatized than lesbian and gay individuals, as they are not only more disliked than lesbian and gay people, but also struggle to find acceptance within the lesbian and gay community.

Discrimination of those who are sexual minorities and mentally ill. Although no studies have examined how those who are sexual minorities and mentally ill are perceived affectively and cognitively by others, there is some research on the discrimination, rejection, and exclusion they suffer as double minorities. In a qualitative study that interviewed individuals who were both mentally ill and lesbian, gay, bisexual, and transgender (LGBT+), these individuals discussed how their experiences of stigmatization were brought about through the combination of their denigrated identities (Kidd et al., 2011). They reported feeling as though they did not belong in either LGBT+ spaces or the mental health patient community, and reported instances of being rejected by friends and family, leading to limited social support. Moreover, due to having two stigmatized identities, depending on context they would have to hide one or both identities for social acceptance, which was difficult and upsetting. These findings were also found by Harris and Licata (2000), who found that sexual and gender minorities with serious mental illnesses feel rejected and excluded from general society and mental health services due to their sexual orientation, and experience rejection and exclusion from the sexual minority community for their mental health status. Both of these studies found that individuals who were both sexual minorities and had a mental illness reported facing large amounts of prejudice due to an interaction between both of their marginalized identities.

Current Study and Hypotheses

The following study explored whether the Double Stigma hypothesis applies to mental illness and sexual orientation. Specifically, this study examined people's affective and cognitive reactions toward hypothetical individuals who both have a mental illness and identify as a sexual minority. Although research have found that non-straight individuals with a mental illness report experiencing more prejudice, currently there is a lack of literature that examines societal perception of sexual minority individuals with mental illnesses, as well as a dearth in studies that examine this issue quantitatively and experimentally. I planned to use a 2 (Mental illness: no mental illness, bipolar disorder) x 3 (sexual orientation: heterosexual, gay, bisexual) between-subjects Multivariate Analysis of Variance (MANOVA) to analyze the relationship between the two independent variables (target's mental health status and sexual orientation), and six dependent variables: social distance, comfort, fear, hostility, warmth, and competence. Bipolar disorder was chosen as the mental illness the vignette target would have because people with bipolar disorder are rated neither high nor low in warmth or competence (Sadler et al., 2012), indicating that they are stigmatized, but not to an extreme degree. A more stigmatized disorder (such as schizophrenia; Sadler et al., 2012) was not chosen out of the concern that mental health stigma would overpower sexuality stigma, making an interaction more difficult to capture. Overall, I predicted that there would be a significant interaction effect for mental illness and sexual orientation conditions on the dependent variables.

H1. Specifically, I predicted that participants who were in the straight, no mental illness (NMI) condition would report feeling more positively toward the vignette target, want the least social distance, and rate the vignette target highest in competence compared to participants in the

other five conditions. The target will be rated lower in warmth than those in the bisexual and gay conditions.

H2. Those who were in the sexual minority NMI conditions (gay, bisexual) would report feeling less positive towards the vignette target, want more social distance, and rate the vignette higher in warmth but lower in competence in comparison to those in the straight NMI condition.

H3: Those who were in the straight bipolar condition would report feeling less positive toward the vignette target, want more social distance, and rate the vignette target lower in both warmth and competence than those in the sexual minority NMI conditions.

H4. Those in the gay bipolar condition would report feeling less positive toward the vignette target, want more social distance, and rate the target lower in both warmth and competence than those in the straight bipolar condition.

H5. Those in the bisexual bipolar condition would report feeling the least positive toward the vignette target, want the most social distance, and rate the target lowest in both warmth and competence than participants in the other five conditions. I predicted that these interaction effects would be strongest for those in the bisexual identity conditions due to the strong societal dislike of bisexuals (Herek, 2002; McLean, 2008).

Method

Participants

Participants were recruited via the Communications center at a medium-sized Midwestern university and through Reddit. Participants did not receive any compensation. A G-power analysis determined that a minimum of 180 participants (or 30 participants per condition) should be collected for the appropriate amount of power. A total of 268 participants were

initially collected, and 72 participants were excluded for failing the manipulation check ($n = 14$) or for providing incomplete data ($n = 58$). Subsequent data analyses included 196 participants (see Table 1 in Appendix A for more detailed demographics). The majority of the sample was female (76.0% female, 20.9% male, 2.0% nonbinary, 1.0% other), and straight/heterosexual (73.0% straight/heterosexual, 12.2% bisexual/pansexual, 5.6% gay/lesbian, 3.1% asexual, 6.1% other). The majority of participants reported being White-American (92.9% White-American, 3.1% Mixed race, 1.0% Black-American, 1.0% Asian/Pacific Islander/Native Hawaiian). A small portion of participants reported their ethnicity as Jewish (1.5%) or Hispanic/Latinx (4.6%), and approximately half of Hispanic/Latinx participants only provided information about their ethnicity and did not provide racial information. Nearly half the sample reported being students (45.4%) and only 2% of participants identified as transgender. Nearly half the sample (44.4%) had reported being diagnosed with a mental illness. The mean age for participants was 30.68 (Range: 18-76).

Materials

Vignettes. This study used six versions of a vignette that described a hypothetical male person, including his age, occupation, and interests. The vignette was created by modifying the vignettes used by Dyar and colleagues (2017) which examined negativity towards bisexual individuals. The vignettes varied by the person's sexuality, and the genders of his current partner and previous partners, which were used to indicate sexual orientation, and by whether the person has a mental illness or not (see Appendix B for vignettes). I used the same sexuality manipulation used by Dyar et al. (2017), stating sexuality in the list of demographics and depicting sexuality in the vignette through the genders of current and previous partners. For the

bisexual condition, the gender of his current partner was not specified, as bisexual individuals may be perceived differently based on the gender of their partners (Dyar et al., 2017). To examine mental illness stigma, the vignette stated that the target went to visit a psychologist and either did not meet the criteria for a diagnosis of bipolar disorder or did meet the criteria.

Affective Measure. How participants felt towards the vignette target was measured using the emotion scale found in Glick, Gangl, Gibb, Klumpner, and Weinberg's (2007) study on masculinity threat and affect towards masculine and feminine gay men (see Appendix C for affective measure). This scale was chosen to provide more understanding of how participants were reacting to the vignette targets. Glick and colleagues (2007) used three scales to assess the feelings their participants had towards their vignette targets: Fear (intimidation, insecurity, nervous, fearful), Hostility (anger, disgust, frustration, annoyance, contempt, superiority), and Comfort (comfort, admiration, calm, content, secure, sympathetic, respectful). The Comfort scale was reverse-scored in order to have the same direction as Fear and Hostility. The items were scored using a 1 (*Not at all*) to 7 (*Extremely*) Likert-type scale. Scores for each scale were averaged across items, with higher scores indicating more negative feelings, such as more Fear, more Hostility, and less Comfort (Glick et al., 2007). Glick and colleagues (2007) reported finding the internal consistency was acceptable to good, with the Fear scale having an internal consistency of 0.80 for effeminate gay male targets (EGM) and 0.72 for masculine gay male targets (MGM); the Hostility scale having an internal consistency of 0.87 for EGM targets and 0.80 for MGM targets; and the Comfort scale having an internal consistency of 0.85 for EGM targets and 0.80 for MGM targets (Glick et al., 2007). In the present study, the scales all had acceptable to good reliability (Comfort Cronbach's $\alpha = 0.84$; Fear Cronbach's $\alpha = 0.83$; Hostility

Cronbach's $\alpha = 0.79$). However, unfortunately there was no discussion of validity so it is unclear how valid this scale is for use. This scale was chosen despite this due to the limited options in measuring affective stigma towards an individual.

Warmth/Competence. Warmth and competence were assessed using 12 descriptors from the Warmth/Competence scale (e.g. efficient, sincere; see Appendix D for warmth/competence scale; Fiske et al., 2002). The Warmth/Competence scale was chosen as it is a well-respected measure that is especially useful for examining stereotypes, as currently it is believed that all stereotypes can be reduced largely to traits of warmth and competence (Fiske et al., 2002). The items were scored on a Likert-type scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*). Scores for each scale were determined by averaging across items. Higher scores for each scale indicate more warmth or competence. The reliability for both the warmth and competence subscales are good for 23 target groups, with the warmth scale having an internal consistency of 0.82 for both students and non-students, and the competence scale's internal consistency being 0.90 for students and 0.85 for non-students (Fiske et al., 2002). In the present study, both scales had excellent internal consistency, as the warmth scale had an internal consistency of 0.95, and the competence scale had an internal consistency of 0.91. There is also evidence for validity of the scale, as the four cluster groups (high warmth/high competence, high warmth/low competence, low warmth/high competence, and low warmth/low competence) have been demonstrated to be valid by Fiske and colleagues (2002).

Social Distance. Prejudice was measured using the Social Distance Scale (see Appendix E for social distance scale; Link, Cullen, Frank, & Wozniak, 1987), which has traditionally been used in examining stigma, especially towards the mentally ill (Link et al., 2004). Social Distance

is frequently used to examine stigma as it indicates rejection of stigmatized groups. It is a proxy of behavior, but ultimately is an affective measure which indicates how participants feel about a group (Karakayali, 2009; Lauber et al., 2004). This is valuable as a measure as endorsing a stereotype can lead to rejection, but this is not always true; typically how a person feels about a group mediates the link between stereotypical beliefs and actions (Cuddy, Fiske, & Glick, 2007). There are 7 items rated on a 4-point Likert-type scale in which participants answer how willing they are (*3 = Definitely unwilling, 2 = Probably unwilling, 1 = Probably willing, 0 = Definitely willing*) to interact with the vignette target in a variety of relationships that differ in closeness (“How would you feel having someone like Alan as a neighbor?”). The items’ scores were added together to create a total score with a maximum possible score of 21. A higher score indicates less willingness to interact, and thus more rejection and prejudice. Previous studies have found that the Social Distance Scale has good internal consistency reliability (Cronbach’s α), ranging from 0.75 to over 0.90 (Link et al., 2004). In the present study, the internal consistency for this scale was good at 0.86. This scale also demonstrates good construct validity (Link et al., 1987).

Procedure

Participants signed an informed consent form, in which they were told that the study was examining how impressions were formed based on limited information. Participants reported their age, gender, whether or not they were transgender, sexual orientation, and race/ethnicity (see Appendix F for demographics questions). Participants were then randomly assigned a vignette, asked to read the vignette carefully, and answered manipulation and attention check questions about the vignette target’s age, race, relationship status, sexual orientation, occupation, mental health status, and interests. After reading the vignette, the participants were asked to rate

how they felt towards the vignette subject by indicating their level of comfort, hostility, and fear. They then rated the subject on warmth and competence traits on a 7-point Likert-type scale. Finally, they rated how much social distance they would want from the vignette target on the social distance scale before reading a debriefing (see Appendix G for debriefing).

Results

Before testing my hypotheses, I ran assumption analyses. I found that there were issues with the presence of outliers and univariate normality. Additionally, the Box's M value of 177.33 was associated with a p -value of under .001, which indicated that the assumption of homogeneity of variance-covariance matrices was not met according to the guidelines set by Huberty and Petoskey (2000). All other assumptions were met, namely multivariate normality, linearity, reliability of covariates, and absence of multicollinearity and singularity. Further exploration found that the majority of assumption issues came from the Fear and Hostility measures. Due to extreme skew and kurtosis, any variation in response was considered an outlier. I conducted an inverse transformation to try to fix the issues of normality, but was unsuccessful. Given these issues, I seriously considered whether to keep or drop the scales Fear and Hostility. Although they were variables I wished to examine, their lack of validity or wide use indicated that it was wiser to drop them from the analyses. They were also not as central to my research as the variables of social distance and warmth/competence, which have more empirical support. After this, I reran the assumptions and found that all assumptions were met, including an absence of outliers and univariate normality. Moreover, the Box's M value of 50.76 was associated with a p -value of .56, indicating that the Box's M was not significant and thus the assumptions of homogeneity of variance-covariance matrices was met.

The set of dependent variables (comfort, warmth, competence, and social distance) was analyzed with a 2 (Mental Health Status: mentally ill vs not mentally ill) x 3 (Sexuality: straight, gay, bisexual) between-subjects MANOVA test. It was predicted that mental illness and sexuality would have an interaction effect across all dependent variables, and that those who were non-straight and mentally ill would be rated the most negatively (i.e. lowest on warmth, competence, and comfort, and highest on social distance). It was also predicted that sexuality and mental health would have a main effect on all dependent variables.

Contrary to my hypothesis, the results indicated no significant interaction between mental health status and sexuality on the dependent variables ($F(8, 368) = .81, p = .59$; Wilk's $\Lambda = .97$, partial $\eta^2 = .02$). There was also no significant main effect for mental health ($F(4, 184) = 1.97, p = .10$; Wilk's $\Lambda = .96$, partial $\eta^2 = .04$). However, there was a significant main effect for sexuality ($F(8, 368) = 2.14, p = .03$; Wilk's $\Lambda = .91$, partial $\eta^2 = .05$; see Table 2 in Appendix H). A test of between-subjects effects showed that there was a significant difference between conditions for warmth ($F(2, 187) = 4.84, p \leq .01$; partial $\eta^2 = .05$) and social distance ($F(2, 187) = 4.50, p = .01$; partial $\eta^2 = .05$; see Figure 1 in Appendix I). A Tukey post-hoc test found that participants rated the straight targets as significantly less warm as compared to the gay targets ($p = .01$; see Table 3 in Appendix J). However, there was no significant difference between the bisexual targets and the gay targets ($p = .81$), or the bisexual targets and the straight targets ($p = .06$). Additionally, participants reported wanting significantly more social distance from the straight targets than from the gay targets ($p = .01$). There was no significant difference between the bisexual targets and the gay targets ($p = .56$), or between the bisexual targets and the straight targets ($p = .13$).

Exploratory Data Analysis

As was previously stated, information was collected on whether the participants identified as a sexual minority or whether they had ever been diagnosed with a mental illness. This was done to examine whether sharing a marginalized status with the target (i.e. sexual orientation or having a mental illness) may have an effect in whether participants feel stigma towards the target. A large percentage of the sample also reported either being a sexual minority ($n = 48$; 24.5%) or having been diagnosed with a mental illness ($n = 87$; 44.4%). However, statistics indicate that only 4.5% of the general population identifies as a sexual minority and only 18.3% of the general population reports having a mental health diagnosis (Substance Abuse and Mental Health Services Administration, 2017; The Williams Institute, 2019), which indicates the sample might be more inclined to report positively towards these groups as they personally identify with them. To analyze sexual minority identity, all participants who did not identify as straight were collapsed into a broad “sexual minority” category. Although the researcher acknowledges that there are differences between sexual minority groups (such as gay, lesbian, bisexual, pansexual, and asexual) and would have liked to be able to analyze each group separately, the individual groups were not large enough for such analyses to be appropriate.

A MANOVA was run using all previous conditions (target’s sexuality: straight, gay, bisexual; target’s mental health: no diagnosis, bipolar) as independent variables, and including participant’s sexual orientation (straight, sexual minority) and whether they had received a diagnosis (had received a diagnosis, had not received a diagnosis) as additional independent variables ($3 \times 2 \times 2 \times 2$). Only dependent variables that were significant in the previous analysis were used in the exploratory analysis (i.e. warmth, social distance). This was done to understand the significant main effects. The results of the exploratory MANOVA found there were no

significant interactions between any of the independent variables on the dependent variables (see Table 4 in Appendix K). Similar to the previous analyses, only target's sexuality had a significant main effect, whereas target's mental health, participant's mental health, and participant's sexuality did not have significant main effects. A test of between-subjects effects found that target's sexuality had a significant effect on warmth ($F(2, 165) = 4.07, p = .02$; partial $\eta^2 = .05$) and social distance ($F(2, 165) = 3.34, p = .04$; partial $\eta^2 = .04$). A Tukey post hoc test was used to further examine the effect of target's sexuality on warmth and social distance. It was found that participants rated the straight target as significantly lower in warmth ($M = 4.92, 95\% CI [4.56, 5.28]$) than the gay target ($M = 5.65; 95\% CI [5.29, 6.01]; p \leq .01$) and the bisexual target ($M = 5.27, 95\% CI [5.00, 5.54]; p = .04$). However, there was no significant difference between the gay target and the bisexual target ($p = .76$). Moreover, participants reported wanting significantly more social distance from the straight target ($M = 5.14; 95\% CI [3.95, 6.32]$) than from the gay target ($M = 2.93; 95\% CI [1.74, 4.13]; p = .01$). There was not a significant difference between the amount of social distance desired for the bisexual target ($M = 4.03; 95\% CI [3.13, 4.93]$) and the straight target ($p = .17$), or for the bisexual target and the gay target ($p = .47$).

Discussion

Prior research has demonstrated that people who both have a mental illness and identify as a sexual minority report that they feel as though they experience more stigma overall, including from the general public, in LGBT+ community spaces, and in mental health spaces (Harris & Licata, 2000; Kidd et al., 2011). Given these findings, the purpose of this study was to examine whether people who both have a mental illness and are a sexual minority may be

perceived more negatively and receive more prejudice. If people are stigmatizing individuals with both marginalized identities more, those findings should align with and support what people who have a mental illness and are sexual minorities are reporting about their experiences with stigma, and help provide a deeper understanding of their experiences.

The hypotheses all predicted that there would be an interaction between mental health status and sexual orientation, such that participants would rate the non-mentally ill straight target as highest in competence, would want the least social distance from him, and would report the least feelings of discomfort, whereas the participants would rate the bipolar bisexual target as lowest in competence and warmth, would want the most social distance from him, and would report the most feelings of discomfort towards him. This was predicted to be the case as both mental illness and same-sex attraction are stigmatized in the United States, and thus it was expected that these factors would interact in such a way that both being a sexual minority and having a mental illness would bring about the most prejudice. However, the results of our analyses did not support these hypotheses. It was found that there was not an interaction between mental illness and sexual orientation on how the target was rated.

It is important to discuss what this lack of an interaction means for individuals who both have a mental illness and are sexual minorities. In previous studies, these individuals have reported feeling isolated by both the LGBT+ community and the mental health patient community (Harris & Licata, 2000; Kidd et al., 2011). Although both of these identities are likely salient to the individual who has both, it may be that only one identity at a time is salient to those with whom they interact. Thus, although there would not be an interaction between these identities for the stigma they experience, they may experience more prejudice overall due to each

marginalized identity providing more opportunity to be stigmatized and discriminated against in differing contexts. The effect of having two marginalized identities could thus in this case be additive, rather than having an interaction effect.

Moreover, contrary to the hypotheses and prior research (Sadler et al., 2012; Socall & Holtgraves, 1992), the target's mental health status did not impact how he was rated and perceived. However, as predicted, sexual orientation did have a significant impact on how the target was rated on warmth and social distance. I found that participants were more likely to view the straight target as less warm than the gay targets, which was consistent with previous research (Mize & Manago, 2018). Prior research has found that people tend to view straight men as low in warmth, whereas gay men are viewed as high in warmth. This is likely because femininity is associated with warmth, since past findings indicate that straight men are presumed to be more masculine, and men who are attracted to men are presumed to be more feminine (Blashill & Powlishta, 2009; Kite & Deaux, 1987). Notably, past research has also found that straight men are often presumed to be more competent than gay men (Mize & Manago, 2018). However, the present study found that there was not a significant difference in the way people rated the straight targets and the sexual minority targets in competence. These results may have occurred due to social desirability, such that participants might not have wanted to rate the gay targets as low on any positive traits to avoid looking prejudiced. On the other hand, it might be that people might be more inclined to believe that gay men or sexual minorities in general are as competent as straight men. However, this may not be the appropriate conclusion to draw given that research as recent as 2018 continues to suggest that gay men and bisexual men are viewed as less competent than straight men (Mize & Manago, 2018).

Participants also reported wanting more social distance from the straight targets than the gay targets. These results are surprising, as straight people are the majority and most privileged in society, and theoretically should be receiving the least prejudice. Though these results are significant, they may not be meaningful. On average, the straight targets were given a social distance score of 5.18, compared to the gay target's score of 3.50 and the bisexual targets' score of 4.17. Yet, the social distance score has a maximum possible score of 21, so none of the targets were given a large amount of social distance or were highly rejected. Thus, it may be that participants are not necessarily rejecting the straight target more than the gay targets, but demonstrated an inclination to report more social closeness for gay targets.

Interestingly, the sexual minority targets were perceived differently from each other in unexpected ways. Bisexual targets were expected to receive the most discrimination overall, which was not supported. Thus, these findings are inconsistent with previous research indicating that people still hold prejudicial attitudes towards bisexual people (Dyar et al., 2017). Moreover, it was predicted that gay targets would be stigmatized, though to a lesser degree than bisexual targets. Yet, despite how previous research has shown that bisexual and gay people are perceived differently (Dyar et al., 2017; Mize & Manago, 2018), neither of the current study's analyses found this effect. Additionally, gay targets were rated the most positively overall, even more than straight targets. Gay targets received the least social distance and the highest scores of warmth.

A possible explanation for these results comes from intergroup anxiety theory (Stephan, 2014). Intergroup anxiety is a form of anxiety an individual may experience when expecting to engage or when engaging in an intergroup interaction. Previous research has found that intergroup anxiety can increase people's positive behaviors towards an outgroup member, which

may be the result of trying to appear non-prejudiced (Vorauer, 2006; Vorauer, 2013). This can include concealment of negative feelings, which may potentially explain why individuals were reluctant to indicate a desire for social distance towards the gay vignette targets. However, anxiety towards interacting with the target was not measured, and thus it is unclear whether intergroup anxiety impacted the results. Another potential explanation is social desirability bias, such that participants may have been able to recognize that the study was examining prejudice towards the target, and thus may have rated the target in less prejudicial ways in order to project a socially desirable, tolerant image. Unfortunately, a social desirability measure was not included in the current study, so it is uncertain whether social desirability impacted the study's results.

Vignettes

The vignettes were adapted from Dyar and colleagues' (2017) study on binegative stereotypes. In the original study, the vignettes were found to be an effective prompt and differences between sexuality were found, such that bisexual people were viewed the most negatively. However, it may be possible that including two marginalized identities took away the focus from either one identity, so that neither identity was salient enough to create differences in perceptions. On the other hand, it may be that both identities were salient, but individual participants may have tended to focus only on one identity. This could have led to a lack of significant differences due to too much variance in participant reactions. Moreover, this would also explain the lack of an interaction effect. If participants only focused on one identity at a time, the other identity likely would not have been making an impact on their perceptions, and thus would not have been providing an interaction effect. It is also possible that participants were not deeply considering the vignette target as he is a hypothetical person rather than a real

individual they might know and meet. Thus, they may not have been putting serious consideration in how they would perceive the vignette target or feel towards him.

Scales

It is possible that the results of the analyses indicate a problem with the way the scales were used. A potential limitation is that the Warmth and Competence scales are commonly used to explore how people believe society views a group, rather than how the participant views a hypothetical individual in a vignette. Although I had not anticipated this discrepancy in usage would cause any problems, it may be that the Warmth and Competence scales are not appropriate for use on how a participant views an individual. Another limitation is that two of the subscales, Fear and Hostility, in the scale taken from Glick and colleagues (2007) had severe issues with normality in the current study, and thus had to be dropped. Participants frequently reported the lowest possible value when answering regarding their feelings towards the target. This may be due to the extremity of the constructs, as fear and hostility are rather intense emotions, and did not appear to accurately reflect how this sample felt towards the vignette targets. Additionally, the scale has only been used to examine attitudes towards sexual minorities, not people with mental illnesses or people who both have a mental illness and are a sexual minority. It may not have then been appropriate to use to examine attitudes towards the vignette target. The scale also is not widely used and thus has not been validated with many samples. Moreover, it was not validated even within the study in which it was constructed. Thus, it may not have been the most appropriate for use with the sample in the current study. However, currently there is a lack of scales that examine affective aspects of prejudice towards an individual, as opposed to a group, and hence the scale was chosen due to a lack of viable alternatives.

Additionally, the results indicated that participants wanted more social distance from the straight targets as opposed to the gay targets. A potential explanation for these results is that social distance scales may not be appropriate for examination of sexual prejudice or intersectionality. Although social distance is a common measure for assessing prejudice towards those with mental illnesses, social distance has not frequently been used to study sexual prejudice, and thus does not have much evidence for the validity of the measure in assessing sexual prejudice. Moreover, the social distance scale was constructed in 1987 and was based on Bogardus' work in the 1940's, and people's expressions of prejudice may have changed vastly since that time. Given this, social distance may not be accurately capturing people's actual attitudes towards sexual minorities in the present study.

People might also have more nuanced and subtle feelings towards those with mental illnesses and those who are sexual minorities than these scales are able to accurately capture. For example, the Modern Homonegativity Scale (Morrison & Morrison, 2003) was constructed due to the change in people's expressions of prejudice towards sexual minorities, as people are less inclined to report old-fashioned prejudice towards gay men and lesbian women. It may be that the scales used are not accurately capturing people's more nuanced feelings and attitudes towards the vignette target, and that any prejudice they may feel towards the vignette target is simply not being found due to the lack of subtlety in the scales.

Sample

There may be some limitations with the generalizability of the sample. As all the participants in the final analyses were recruited from the Communications center of the university at which the study was conducted, the majority of participants were likely connected

to the university and may have more education and experiences than the general public. This may affect the way they view people who have mental illnesses and people who are sexual minorities, as prior research indicates that higher levels of education are associated with lower levels of multiple forms of prejudice (Carvacho et al., 2013). Moreover, almost every participant reported knowing somebody who has a mental illness ($n = 189$; 96.4%) or is a sexual minority ($n = 193$; 98.5%), which may be more than the general public. Previous research has found that 63% of participants reported knowing someone who is a sexual minority (Stuber, Rocha, Christian, & Link, 2014), which is far less than the current's study percentage. A Pew research survey (2013) found that 87% of the public reported knowing someone who was gay or lesbian. Although this is similar to the percentage of the current study's participants who report knowing a sexual minority, the current study's sample still reports knowing sexual minorities at a higher rate than the general public. As contact with marginalized groups frequently decreases prejudice towards those groups (Pettigrew, Tropp, Wagner, & Christ, 2011), because this sample has more contact than the general public with people who have mental illness or who are sexual minorities, this may explain why they did not show prejudiced attitudes towards the vignette target.

It should be acknowledged that although this study was conducted under the assumption that the research discussed in the literature review is still relevant for people's attitudes towards those who are sexual minorities and those who have a mental illness, it is possible that the sample truly does not feel prejudice towards the vignette target based either on his sexual orientation or mental health status. This could indicate that people feel more positively about sexual minorities and people with mental illnesses than past studies have indicated, as attitudes towards sexual minorities have grown more positive overall in the past two decades (Pew

Research Center, 2017), and may have grown more positive towards people who have mental illnesses.

A strength of this study was that I tried to ensure that a representative sample was acquired. For example, there was no information about sexuality, mental illness, prejudice, or stigma in the recruitment procedures or the informed consent, which could have resulted in a sampling bias of those interested in those issues. Additionally, I tried to sample from the general population through Reddit, and avoided a strictly student sample by using the communications center. Another strength of this study is that it is the only study to my knowledge that examines how people perceive those who are both sexual minorities and have a mental illness, making it a novel area of study. Future studies should continue to research how the general public views sexual minorities and people with mental illness. This is important to determine the relationship between the lived experiences of those with both identities and the way they are perceived societally.

Conclusion

This study is one of the first to examine how people are perceiving those who are both sexual minorities and have a mental illness. Given that this area is new and research on intersectionality with mental illness is rarely studied, future research should continue to explore how people with both marginalized identities are perceived in the general population. Future studies should ensure that a more representative sample is chosen and use scales that more accurately captures how people currently feel towards sexual minorities and those with mental illnesses. Moreover, once more is understood about how these identities do or do not impact those who have both, social justice interventions can be developed. For example, although these

identities might not interact, they might have additive effects, which could mean that although only one identity might be salient in a given situation, there could be more situations in which they experience prejudice due to having more than one identity. Should research find evidence for this, LGBT+ communities and mental health spaces may want to work to ensure that they are making their spaces more inclusive towards the other identity to reduce the minority stress experienced by their members with both identities.

References

- Alarie, M. & Gaudet, S. (2013). "I don't know if she is bisexual or if she just wants to get attention": Analyzing the various mechanisms through which emerging adults invisibilize bisexuality. *Journal of Bisexuality*, 13, 191-214. doi: 10.1080/15299716.2013.780004
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of counseling psychology*, 54, 306-319. doi: 10.1037/0022-0167.54.3.306
- Beckett, C. (2004). Crossing the border: Locating heterosexuality as a boundary for lesbian and disabled women. *Journal of International Women's Studies*, 5, 44-52.
- Berzins, K. M., Petch, A., & Atkinson, J. M. (2003). Prevalence and experience of harassment of people with mental health problems living in the community. *The British Journal of Psychiatry*, 183, 526-533. doi: 10.1192/02-440
- Blashill, A. J., & Powlishta, K. K. (2009). Gay stereotypes: The use of sexual orientation as a cue for gender-related attributes. *Sex Roles*, 61, 783-793. doi: 10.1007/s11199-009-9684-7
- Bogardus, E. S. (1947). Measurement of personal-group relations. *Sociometry*, 10, 306-311. doi: 10.2307/2785570
- Borver, J., Gurevich, M., & Mathieson, C. (2001). (Con)tested identities: Bisexual women reorient sexuality. *Journal of Bisexuality*, 2, 23-52. doi: 10.1300/J159v02n02_03
- Bowleg, L. (2013). "Once you've blended the cake, you can't take the parts back to the main

- ingredients”: Black gay and bisexual men’s descriptions and experiences of intersectionality. *Sex Roles*, 68, 754–767. doi: 10.1007/s11199-012-0152-4
- Bowman, J. T. (1987). Attitudes toward disabled persons: Social distance and work competence. *Journal of Rehabilitation*, 53, 41.
- Carvacho, H., Zick, A., Haye, A., González, R., Manzi, J., Kocik, C., & Bertl, M. (2013). On the relation between social class and prejudice: The roles of education, income, and ideological attitudes. *European Journal of Social Psychology*, 43, 272-285. doi: 10.1002/ejsp.1961
- Cohen, T. R., Hall, D. L., & Tuttle, J. (2009). Attitudes toward stereotypical versus counterstereotypical gay men and lesbians. *The Journal of Sex Research*, 46, 274-281. doi:10.1080/00224490802666233
- Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American journal of preventive medicine*, 23, 260-268. doi: 10.1016/S0749-3797(02)00514-7
- Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice*, 7, 48–67. doi: 10.1093/clipsy.7.1.48
- Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia bulletin*, 30, 481-491. doi: 10.1093/oxfordjournals.schbul.a007096
- Corrigan, P. W., Powell, K. J., & Michaels, P. J. (2013). The effects of news stories on the

- stigma of mental illness. *The Journal of nervous and mental disease*, 201, 179-182.
doi: 10.1097/NMD.0b013e3182848c24
- Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., Goldstein, H., ... Kubiak, M. A. (1999). Stigmatizing attributions about mental illness. *Journal of Community Psychology*, 28, 91-102. doi: 10.1002/(SICI)1520-6629(200001)28:1<91::AID-JCOP9>3.0.CO;2-M
- Corrigan, P., Thompson, V., Lambert, D., Sangster, Y., Noel, J. G., & Campbell, J. (2003). Perceptions of discrimination among persons with serious mental illness. *Psychiatric Services*, 54, 1105-1110. doi: 10.1176/appi.ps.54.8.1105
- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D.T. Gilbert & S.T. Fiske (Eds.), *The Handbook of Social Psychology*, (pp. 504–553). Boston, MA: McGraw-Hill
- Cuddy, A. J., Fiske, S. T., & Glick, P. (2007). The BIAS map: behaviors from intergroup affect and stereotypes. *Journal of personality and social psychology*, 92, 631-648.
doi: 10.1037/0022-3514.92.4.631
- David, S., & Knight, B. G. (2008). Stress and coping among gay men: Age and ethnic differences. *Psychology and Aging*, 23, 62-69. doi: 10.1037/0882-7974.23.1.62
- Dolan, C. V. (2013). Transcending monosexism: Breaking cycles and a call for nonmonosexual liberation. *The Vermont Connection*, 34. Retrieved from
<https://scholarworks.uvm.edu/tvc/vol34/iss1/4/>
- Dyar, C., Lytle, A., London, B., & Levy, S. R. (2017). An experimental investigation of the application of binegative stereotypes. *Psychology of Sexual Orientation and Gender Diversity*, 4, 314–327. doi: 10.1037/sgd0000234

- Eliason, M. J. (1997). The prevalence and nature of biphobia in heterosexual undergraduate students. *Archives of Sexual Behavior*, 26, 317-326. doi: 10.1023/A:1024527032040
- Eliason, M. (2001). "Bi-negativity: The stigma facing bisexual men." *Journal of Bisexuality*, 1, 137-154. doi: 10.1300/J159v01n02_05
- Eliason, M., Donelan, C., & Randall, C. (1992). Lesbian stereotypes. *Health Care for Women International*, 13, 131-144. doi: 10.1080/07399339209515986
- Fiske, S. T. (2012). Warmth and competence: Stereotype content issues for clinicians and researchers. *Canadian Psychology/Psychologie Canadienne*, 53, 14-20.
doi: 10.1037/a0026054
- Fiske, S. T., Cuddy, A. J. C., Glick, P., & Xu, J. (2002). A model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. *Journal of Personality and Social Psychology*, 82, 878-902.
doi: 10.1037//0022-3514.82.6.878
- Frost, D. M., Lehavot, K., & Meyer, I. H. (2015). Minority stress and physical health among sexual minority individuals. *Journal of Behavioral Medicine*, 38, 1-8.
doi: 10.1007/s10865-013-9523-8
- Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, 26, 979-999. doi: 10.1080/01612840500280638
- Glick, P., Gangl, C., Gibb, S., Klumpner, S., & Weinberg, E. (2007). Defensive reactions to masculinity threat: More negative affect toward effeminate (but not masculine) gay men. *Sex Roles*, 57, 55-59. doi: 10.1007/s11199-007-9195-3
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs,

NJ: Prentice Hall

Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., ... & Swanson, J. (2001). Recent victimization in women and men with severe mental illness: prevalence and correlates. *Journal of Traumatic Stress, 14*, 615-632.
doi: 10.1023/A:1013026318450

Harris, H. L., & Licata, F. (2000). From fragmentation to integration: Affirming the identities of culturally diverse, mentally ill lesbians and gay men. *Journal of Gay & Lesbian Social Services, 11*, 93-103. doi: 10.1300/J041v11n04_05

Hayes, J. A., Chun-Kennedy, C., Edens, A., & Locke, B. D. (2011). Do double minority students face double jeopardy? Testing minority stress theory. *Journal of College Counseling, 14*, 117-126. doi: 10.1002/j.2161-1882.2011.tb00267.x

Herek, G. M. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*, 316-333.
doi: 10.1177/088626090005003006

Herek, G. M. (2002). Heterosexuals' attitudes toward bisexual men and women in the United States. *The Journal of Sex Research, 39*, 264-274. doi: 10.1080/00224490209552150

Herek, G. M. (2009). Hate crimes and stigma-related experiences among sexual minority adults in the United States: Prevalence estimates from a national probability sample. *Journal of interpersonal violence, 24*, 54-74. doi: 10.1177/0886260508316477

Hinrichs, D. W., & Rosenberg, P. J. (2002). Attitudes toward gay, lesbian, and bisexual persons among heterosexual liberal arts college students. *Journal of homosexuality, 43*, 61-84.
doi: 10.1300/J082v43n01_04

- Huberty, C. J., & Petoskey, M. D. (2000). Multivariate analysis of variance and covariance. In *Handbook of applied multivariate statistics and mathematical modeling* (pp. 183-208). Academic Press.
- Huddy, L., & Terkildsen, N. (1993). The consequences of gender stereotypes for women candidates at different levels and types of office. *Political Research Quarterly*, 46, 503-525. doi: 10.1177/106591299304600304
- Hunter, E. (2008). What's good for the gays is good for the gander: Making homeless youth housing safer for lesbian, gay, bisexual, and transgender youth. *Family Court Review*, 46, 543-557. doi: 10.1111/j.1744-1617.2008.00220.x
- Jost, J. T., & Kay, A. C. (2005). Exposure to benevolent sexism and complementary gender stereotypes: consequences for specific and diffuse forms of system justification. *Journal of Personality and Social Psychology*, 88, 498. doi: 10.1037/0022-3514.88.3.498
- Karakayali, N. (2009). Social distance and affective orientations. *Sociological Forum*, 24, 538-562. doi: 10.1111/j.1573-7861.2009.01119.x
- Kidd, A., Veltman, A., Gately, C., Chan, K. J., & Cohen, J. N. (2011). Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. *American Journal of Psychiatric Rehabilitation*, 14, 13-39. doi: 10.1080/15487768.2011.546277.
- Kite, M. E., & Deaux, K. (1987). Gender belief systems: Homosexuality and the implicit inversion theory. *Psychology of Women Quarterly*, 11, 83-96. doi: 10.1111/j.1471-6402.1987.tb00776.x
- Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on

- production, content, and influences. *Journal of health communication*, 13, 434-449.
doi: 10.1080/10810730802198813
- LaMar, L., & Kite, M. E. (1998). Sex differences in attitudes toward gay men and lesbians: A multidimensional perspective. *The Journal of Sex Research*, 35, 189-196.
doi: 10.1080/00224499809551932
- LeBeau, R. T., & Jellison, W. A. (2009). Why get involved? Exploring gay and bisexual men's experience of the gay community. *Journal of Homosexuality*, 56, 56-76.
doi: 10.1080/00918360802551522
- Lauber, C., Nordt, C., Falcato, L., & Rössler, W. (2004). Factors influencing social distance toward people with mental illness. *Community Mental Health Journal*, 40, 265-274.
doi: 10.1023/B:COMH.0000026999.87728.2d
- Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American journal of Sociology*, 92, 1461-1500. doi: 10.1086/228672
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385. doi: 10.1146/annurev.soc.27.1.363
- Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia bulletin*, 30, 511-541. doi: 10.1093/oxfordjournals.schbul.a007098
- McKirnan, D. J., Stokes, J. P., Doll, L., & Burzette, R. G. (1995). Bisexually active men: Social characteristics and sexual behavior. *Journal of Sex Research*, 32, 65-76.
doi: 10.1080/00224499509551775
- McLean K. (2008). Inside, outside, nowhere: Bisexual men and women in the gay and lesbian

- community. *Journal of Bisexuality*, 8, 63-80. doi: 10.1080/15299710802143174
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38-56. doi: 10.2307/2137286
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674–697. doi: 10.1037/0033-2909.129.5.674
- Mize, T. D., & Manago, B. (2018). The stereotype content of sexual orientation. *Social Currents*, 5, 1-21. doi: 10.1177/2329496518761999
- Morris, J. F., & Rothblum, E. D. (1999). Who fills out a “lesbian” questionnaire? The interrelationship of sexual orientation, years “out,” disclosure of sexual orientation, sexual experience with women, and participation in the lesbian community. *Psychology of Women Quarterly*, 23, 537-557. doi: 10.1111/j.1471-6402.1999.tb00380.x
- Morrison, M. A., & Morrison, T. G. (2003). Development and validation of a scale measuring modern prejudice toward gay men and lesbian women. *Journal of homosexuality*, 43, 15-37. doi: 10.1300/J082v43n02_02
- Morrison, M. A., & Morrison, T. G. (2011). Sexual orientation bias toward gay men and lesbian women: Modern homonegative attitudes and their association with discriminatory behavioral intentions. *Journal of Applied Social Psychology*, 41, 2573-2599. doi: 10.1111/j.1559-1816.2011.00838.x
- Morrison, M. A., Morrison, T. G., & Franklin, R. (2009). Modern and old-fashioned homonegativity among samples of Canadian and American university students. *Journal of Cross-Cultural Psychology*, 40, 523–542. doi: 10.1177/0022022109335053

- Norton, A. T., & Herek, G. M. (2013). Heterosexuals' attitudes toward transgender people: Findings from a national probability sample of US adults. *Sex roles, 68*, 738-753.
doi: 10.1007/s11199-011-0110-6
- Olmsted, D. W., & Durham, K. (1976). Stability of mental health attitudes: A semantic differential study. *Journal of Health and Social Behavior, 17*, 35-44.
doi: 10.2307/2136465
- Owen, P. R. (2012). Portrayals of schizophrenia by entertainment media: a content analysis of contemporary movies. *Psychiatric Services, 63*, 655-659.
doi: 10.1176/appi.ps.201100371
- Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research, 40*, 384-399. doi: 10.1007/s10488-012-0430-z
- Parent, M. C., DeBlaere, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles, 68*, 639-645.
doi: 10.1007/s11199-013-0283-2
- Pettigrew, T. F., Tropp, L. R., Wagner, U., & Christ, O. (2011). Recent advances in intergroup contact theory. *International journal of intercultural relations, 35*, 271-280.
doi: 10.1016/j.ijintrel.2011.03.001
- Pew Research Center (2013). *A survey of LGBT Americans: Attitudes, experiences and values in changing times*. Washington, D.C. Retrieved from
<http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/>
- Pew Research Center (2015). *Most Americans now say learning their child is gay wouldn't upset*

- them*. Washington, D.C. Retrieved from <http://www.pewresearch.org/fact-tank/2015/06/29/most-americans-now-say-learning-their-child-is-gay-wouldnt-upset-them/>
- Pew Research Center (2016a). *5 key findings about faith and politics in the 2016 presidential race*. Washington, D.C. Retrieved from <http://www.pewresearch.org/fact-tank/2016/01/27/key-findings-faith-and-politics-in-2016-presidential-race/>
- Pew Research Center (2016b). *Deep divides between, within parties on public debates about LGBT issues*. Washington, D.C. Retrieved from <http://www.pewresearch.org/fact-tank/2016/10/04/deep-divides-between-within-parties-on-public-debates-about-lgbt-issues/>
- Pew Research Center (2017). *Homosexuality, gender and religion*. Washington, D.C. Retrieved from <http://www.people-press.org/2017/10/05/5-homosexuality-gender-and-religion/>
- Roberts, T. S., Horne, S. G., & Hoyt, W. T. (2015). Between a gay and a straight place: Bisexual individuals' experiences with monosexism. *Journal of Bisexuality, 15*, 554-569.
doi: 10.1080/15299716.2015.1111183
- Rust, P. C. R. (2000). The biology, psychology, sociology, and sexuality of bisexuality. In P. C. R. Rust (Ed.), *Bisexuality in the United States* (pp. 403–470). New York: Columbia University Press.
- Sadler, M. S., Meagor, E. L., & Kaye, K. E. (2012). Stereotypes of mental disorders differ in competence and warmth. *Social Science & Medicine, 74*, 915-922.
doi: 10.1016/j.socscimed.2011.12.019
- Siegel, K., Lune, H., & Meyer, I. H. (1998). Stigma management among gay/bisexual men with

- HIV/AIDS. *Qualitative Sociology*, 21, 3-24. doi: 10.1023/A:1022102825016
- Servais, L. M., & Saunders, S. M. (2007). Clinical psychologists' perceptions of persons with mental illness. *Professional Psychology: Research and Practice*, 38, 214-219. doi:10.1037/0735-7028.38.2.214
- Socall, D. W., & Holtgraves, T. (1992). Attitudes toward the mentally ill: The effects of label and beliefs. *The Sociological Quarterly*, 33, 435-445. doi: 10.1111/j.1533-8525.1992.tb00383.x
- Spalding, L. R., & Peplau, L. A. (1997). The unfaithful lover: Heterosexuals' perceptions of bisexuals and their relationships. *Psychology of Women Quarterly*, 21, 611-625. doi: 10.1111/j.1471-6402.1997.tb00134.x
- Stafford, M. C., & Scott, R. R. (1986). Stigma, deviance, and social control. In *The dilemma of difference* (pp. 77-91). Springer, Boston, MA.
- Stephan, W. G. (2014). Intergroup anxiety: Theory, research, and practice. *Personality and Social Psychology Review*, 18, 239-255. doi: 10.1177/1088868314530518
- Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry*, 19, 522-526. doi: 10.1097/01.yco.0000238482.27270.5d
- Stuber, J. P., Rocha, A., Christian, A., & Link, B. G. (2014). Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric services*, 65, 490-497. doi: 10.1176/appi.ps.201300136
- Substance Abuse and Mental Health Services Administration (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*(HHS Publication No. SMA 17-5044, NSDUH Series H-

- 52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>
- Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, 7, 225-240. doi: 10.1093/schbul/7.2.225
- Vorauer, J. D. (2006). An information search model of evaluative concerns in intergroup interaction. *Psychological Review*, 113, 862-886.
- Vorauer, J. D. (2013). Getting past the self: Understanding and removing evaluative concerns as an obstacle to positive intergroup contact effects. In G. Hodson & M. Hewstone (Eds.), *Advances in intergroup contact* (pp. 23-48). New York, NY: Psychology Press.
- Weiss, J. T. (2003). GL vs. BT: The archaeology of biphobia and transphobia within the U.S. gay and lesbian community. *Journal of Bisexuality*, 3, 25-55. doi: 10.1300/J159v03n03_02
- Whitley, R., & Berry, S. (2013). Trends in newspaper coverage of mental illness in Canada: 2005–2010. *The Canadian Journal of Psychiatry*, 58, 107-112. doi: 10.1177/070674371305800208
- The Williams Institute (2019). *LGBT Demographic Data Interactive*. Los Angeles, CA. Retrieved from <https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#about-the-data>
- Worthen, M. G. (2013). An argument for separate analyses of attitudes toward lesbian, gay, bisexual men, bisexual women, MtF and FtM transgender individuals. *Sex Roles*, 68, 703-723. doi: 10.1007/s11199-012-0155-1

Yost, M. R., & Thomas, G. D. (2012). Gender and binegativity: Men's and women's attitudes toward male and female bisexuals. *Archives of Sexual Behavior*, *41*, 691–702.
doi: 10.1007/s10508-011-9767-8

Appendix A: Demographics Table

Table 1: *Demographic Characteristics of Participants*

	N	%
Gender		
Male	41	20.9
Female	149	76.0
Nonbinary/Third gender	4	2.0
Other	2	1.0
Transgender		
Is transgender	4	2.0
Is not transgender	192	98.0
Race		
Asian/Pacific Islander/Native Hawaiian	2	1.0
Black/African-American	2	1.0
Hispanic/Latinx	4	2.0
White/European-American	182	92.9
Mixed	6	3.1
Ethnicity		
None	184	93.9
Hispanic/Latinx	9	4.6
Jewish	3	1.5
Student Status		
Nonstudent	107	54.6
Student	89	45.4
Sexual Orientation		
Asexual	6	3.1
Bisexual/Pansexual	24	12.2
Gay/Lesbian	11	5.6
Straight/Heterosexual	143	73.0
Other	7	3.6
Prefer not to say	5	2.6
Mental Illness Diagnosis		
Have been diagnosed	87	44.4
Have not been diagnosed	107	54.6
Age		
18 - 25	112	57.1
26 - 35	26	13.3
36 - 45	22	11.2

46 - 55	16	8.2
56 - 65	12	6.1
66 - 80	8	4.1

Appendix B: Vignettes

Note: Differences in the vignettes are italicized.

Vignette Version 1: Straight, No Mental Illness

Name: Alan

Age: 21

Gender: Male

Sexual Orientation: *Straight*

Occupation: Student

Alan is a 21-year-old student at a nearby university. He is white American, with brown eyes and chestnut hair, and his height is 5'9. Alan has a good sense of humor, is outgoing, and enjoys his program. He likes taking his dog on walks in the park, going to the movies, and photography.

Alan has been with his current *girlfriend* for 2 years. Before his current *girlfriend*, Alan had 2 previous romantic relationships with *Jane and Amy*. Alan likes to spend his free time with his friends and family. *Alan recently saw a psychologist for an intake session, during which he was informed that his psychological distress was within a normal range and that his symptoms did not meet the criteria for a mental illness diagnosis.*

Vignette Version 2: Straight, Mental Illness

Name: Alan

Age: 21

Gender: Male

Sexual Orientation: *Straight*

Occupation: Student

Alan is a 21-year-old student at a nearby university. He is white American, with brown eyes and chestnut hair, and his height is 5'9. Alan has a good sense of humor, is outgoing, and enjoys his program. He likes taking his dog on walks in the park, going to the movies, and photography. Alan has been with his current *girlfriend* for 2 years. Before his current *girlfriend*, Alan had 2 previous romantic relationships with *Jane and Amy*. Alan likes to spend his free time with his friends and family. *Alan recently saw a psychologist for an intake session, during which he was informed that his psychological distress did not fall within a normal range and his symptoms met the criteria for a mental illness diagnosis of bipolar disorder.*

Vignette Version 3: Gay, No Mental Illness

Name: Alan

Age: 21

Gender: Male

Sexual Orientation: *Gay*

Occupation: Student

Alan is a 21-year-old student at a nearby university. He is white American, with brown eyes and chestnut hair, and his height is 5'9. Alan has a good sense of humor, is outgoing, and enjoys his program. He likes taking his dog on walks in the park, going to the movies, and photography. Alan has been with his current *boyfriend* for 2 years. Before his current *boyfriend*, Alan had 2 previous romantic relationships with *James and Oscar*. Alan likes to spend his free time with his friends and family. *Alan recently saw a psychologist for an intake session, during which he was informed that his psychological distress was within a normal range and that his symptoms did not meet the criteria for a mental illness diagnosis.*

Vignette Version 4: Gay, Mental Illness

Name: Alan

Age: 21

Gender: Male

Sexual Orientation: *Gay*

Occupation: Student

Alan is a 21-year-old student at a nearby university. He is white American, with brown eyes and chestnut hair, and his height is 5'9. Alan has a good sense of humor, is outgoing, and enjoys his program. He likes taking his dog on walks in the park, going to the movies, and photography.

Alan has been with his current *boyfriend* for 2 years. Before his current *boyfriend*, Alan had 2 previous romantic relationships with *James and Oscar*. Alan likes to spend his free time with his friends and family. *Alan recently saw a psychologist for an intake session, during which he was informed that his psychological distress did not fall within a normal range and his symptoms met the criteria for a mental illness diagnosis of bipolar disorder.*

Vignette Version 5: Bisexual, No Mental Illness

Name: Alan

Age: 21

Gender: Male

Sexual Orientation: *Bisexual*

Occupation: Student

Alan is a 21-year-old student at a nearby university. He is white American, with brown eyes and chestnut hair, and his height is 5'9. Alan has a good sense of humor, is outgoing, and enjoys his

program. He likes taking his dog on walks in the park, going to the movies, and photography.

Alan has been with his current *partner* for 2 years. Before his current *partner*, Alan had 2 previous romantic relationships with *Jane and Oscar*. Alan likes to spend his free time with his friends and family. *Alan recently saw a psychologist for an intake session, during which he was informed that his psychological distress was within a normal range and that his symptoms did not meet the criteria for a mental illness diagnosis.*

Vignette Version 6: Bisexual, Mental Illness

Name: Alan

Age: 21

Gender: Male

Sexual Orientation: *Bisexual*

Occupation: Student

Alan is a 21-year-old student at a nearby university. He is white American, with brown eyes and chestnut hair, and his height is 5'9. Alan has a good sense of humor, is outgoing, and enjoys his program. He likes taking his dog on walks in the park, going to the movies, and photography.

Alan has been with his current *partner* for 2 years. Before his current *partner*, Alan had 2 previous romantic relationships with *Jane and Oscar*. Alan likes to spend his free time with his friends and family. *Alan recently saw a psychologist for an intake session, during which he was informed that his psychological distress did not fall within a normal range and his symptoms met the criteria for a mental illness diagnosis of bipolar disorder.*

Appendix C: Affective Measure

Thank you for reading that short vignette about Alan. Now, please rate your emotions towards Alan on a 1 (*Not at all*) to 7 (*Extremely*) scale.

Comfort/Discomfort:

- Comfort
- Admiration
- Calm
- Content
- Secure
- Sympathetic
- Respectful

Fear:

- Intimidation
- Insecurity
- Nervous
- Fearful

Hostility:

- Anger
- Disgust
- Frustration
- Annoyance
- Contempt

- Superiority

Appendix D: Warmth/Competence

Instructions: Now, please rate Alan on the following traits using a scale of 1 (*Strongly disagree*) to 7 (*Strongly agree*).

- Efficient
- Skillful
- Capable
- Competent
- Intelligent
- Confident
- Good-natured
- Sincere
- Warm
- Friendly
- Trustworthy
- Well-intentioned

Appendix E: Social Distance

Instructions: Based on the description of Alan, rate the following statements on the following scale:

Definitely willing; Probably willing; Probably unwilling; and Definitely unwilling.

- How would you feel about renting a room in your home to someone like Alan?
- How about as a worker on the same job as someone like Alan?
- How would you feel having someone like Alan as a neighbor?
- How about as the caretaker of your children for a couple of hours?
- How about having your children marry someone like Alan?
- How would you feel about introducing Alan to an attractive person you are friendly with?
- How would you feel about recommending someone like Alan for a job working for a friend of yours?

Appendix F: Demographics Questions

Thank you very much for agreeing to participate in our study! We would like to begin by getting some information about you, our participant.

What is your age? ____

What is your gender?

- Female
- Male
- Nonbinary/Third gender
- Prefer to self-describe _____
- Prefer not to say

Transgender is a term which refers to people who do not identify with the gender assigned to them at birth, such as, for instance, a man who was assigned female at birth or a woman who was assigned male at birth. Other identities that do not fit within the gender binary, such as nonbinary, third gender, genderfluid, and genderqueer also fall under the umbrella of transgender identity.

Do you identify as transgender?

- Yes
- No
- Prefer not to say

Which sexual orientation do you identify as?

- Asexual
- Bisexual/Pansexual

- Gay/Lesbian
- Straight/Heterosexual
- Prefer to self-describe _____
- Prefer not to say

What race and/or ethnicity best fits your identity? You may pick more than one.

- Asian/Pacific Islander/Native Hawaiian
- Black/African-American
- Hispanic/Latinx
- Jewish
- Native American
- White/European-American
- Other _____

Appendix G: Debriefing

Thank you for completing our study. The study you just completed was designed to examine people's perceptions of individuals who are both mentally ill and identify as gay or bisexual. There were several different vignettes you could have read, with the vignette subject differing on their sexual orientation and on why they were seeing a therapist. This study seeks to further research on the perceptions of non-straight, mentally ill individuals in order to better understand their experiences, so that hopefully in the future, we can reduce the prejudice they may face.

If after the study you still have questions or concerns, you may contact the principal investigator at haperezarche@bsu.edu, or her faculty advisor at lnlittleford@bsu.edu.

In order to ensure that our study's results are valid, we must ask that you do not discuss the nature of this study with individuals who have not yet completed the study.

Thank you again for your participation.

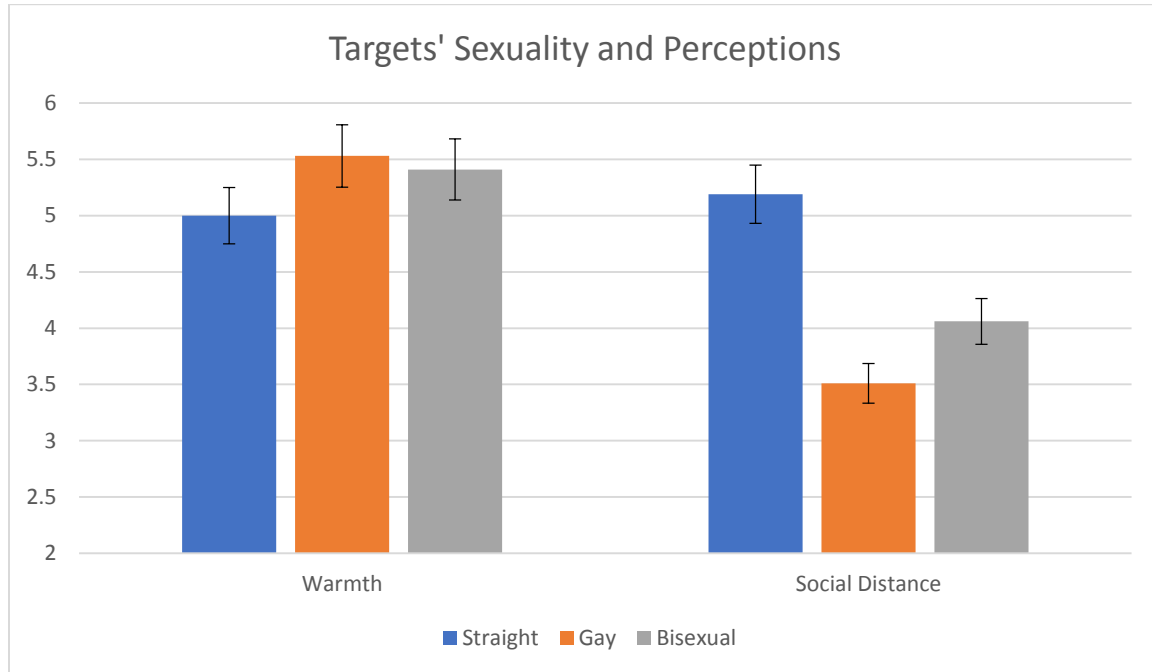
Appendix H: Hypothesis testing multivariate analyses

Table 2: *Multivariate effects of main analyses*

Variables	Wilks' λ	F	df	Error df	Sig.
Target's sexuality (TS)	.91	2.14	8	368	.03*
Target's diagnosis (TD)	.96	1.97	4	184	.10
TS*TD	.97	0.81	8	368	.59

*Significant at .05 level

Appendix I: Mean scores for warmth and social distance across sexuality

Figure 1:

Appendix J: Univariate results for sexuality

Table 3: *Significant univariate effects for sexuality (at $p \leq .05$ level)*

DV	<i>df</i>	<i>df error</i>	<i>F</i>	Sexuality	<i>M</i>	95% <i>CI</i>	
						LB	UB
Warmth	2	187	4.84	Straight	5.00	4.74	5.25
				Gay	5.53	5.28	5.77
				Bisexual	5.41	5.16	5.66
Social Distance	2	187	4.50	Straight	5.19	4.38	5.99
				Gay	3.51	2.73	4.29
				Bisexual	4.06	3.28	4.85

Note: LB and UB represent the lower and upper bounds of the confidence intervals, respectively.

Appendix K: Exploratory analysis results

Table 4: *Multivariate effects of exploratory analyses*

Variables	Wilks' λ	F	df	Error df	Sig.
Target's sexuality (TS)	.94	2.52	4	328	.04*
Target's diagnosis (TD)	.98	1.32	2	164	.27
Participant's sexuality (PS)	.98	2.10	2	164	.13
Participant's mental health (PMH)	.97	2.80	2	164	.06
TS*TD	.97	1.38	4	328	.24
TS*PS	.99	0.50	4	328	.74
TS*PMH	.98	0.76	4	328	.55
TD*PS	.99	0.56	2	164	.57
TD*PMH	.99	0.19	2	164	.83
PS*PMH	.97	2.28	2	164	.11
TS*TD*PS	.99	0.62	4	328	.65
TS*TD*PMH	.98	0.78	4	328	.54
TS*PS*PMH	.99	0.48	4	328	.75
TD*PS*PMH	.99	0.54	2	164	.58
TS*TD*PS*PMH	.99	0.07	4	328	.99

Note: * = significant at .05 level